



**PHYSICIAN'S HEALTH SUMMARY  
FIRST STEPS EARLY INTERVENTION SYSTEM  
CHILDREN'S SPECIAL HEALTH CARE SERVICES**

State Form 51929 (R2 / 1-07) / BCD 0119

Division of Disability and Rehabilitative Services



Effective May 01, 2006

Your patient is currently in the evaluation process for eligibility for CSHCS and/or early intervention services under Part C of the Individuals with Disabilities Education Act (IDEA). The health summary request is an initial step in this process. Your participation is requested by completing and returning this form. If you have questions, please contact the Intake / Service Coordinator listed below. Your participation in this activity is greatly appreciated.

IDENTIFYING INFORMATION	
Name of child	Date of birth (month, day, year)
Name of parent / guardian	County
Reason(s) for referral	
CURRENT HEALTH STATUS	
Diagnosed medical condition (please specify)	ICD codes (highest specificity)
Current medications	
Medical precautions	Are immunizations current? <input type="checkbox"/> Yes <input type="checkbox"/> No
Physical status	
Please note any concerns with vision or hearing	
DIAGNOSED PHYSICAL OR MENTAL CONDITION WITH A HIGH PROBABILITY OF DELAY	
Please check all that apply. Please use code with highest available specificity.	
<input type="checkbox"/> Chromosomal abnormalities or genetic disorder	ICD Code: _____
<input type="checkbox"/> Neurological disorder	ICD Code: _____
<input type="checkbox"/> Congenital Malformation	ICD Code: _____
<input type="checkbox"/> Sensory impairments, including vision or hearing	ICD Code: _____
<input type="checkbox"/> Severe toxic exposure including prenatal exposure	ICD Code: _____
<input type="checkbox"/> Low birth weight $\leq$ 1500 grams	ICD Code: _____
<input type="checkbox"/> Neurological abnormality in the newborn period	ICD Code: _____
Please indicate specific concerns or comments related to the child's development below.	
<hr/>	
<input type="checkbox"/> I recommend and authorize a developmental assessment be provided to the child to rule out a developmental delay in one or more of the following developmental domains under V 79.3:	
<input type="checkbox"/> Cognitive development	<input type="checkbox"/> Physical development (including vision or hearing)
<input type="checkbox"/> Adaptive development	<input type="checkbox"/> Social or emotional development
<input type="checkbox"/> Communication development	
Signature of parent (Signature on this form authorizes First Steps to provide a comprehensive developmental assessment to determine the level of the child's development and to identify if a developmental delay is present.)	
Date (month, day, year)	
Signature of physician	
Date (month, day, year)	
Name of physician (please print)	
Telephone number (       )	
Please return to:	
Telephone number (       )	Fax number (       )

**DISTRIBUTION:** Original - SPOE; Copy - Primary care physician and family